Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		005043	B. WING		04/06/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
ST JOSEPH HOSPITAL 700 BROADW FORT WAYNE						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
S 000	INITIAL COMMENTS		S 000			
	This is a State hospita	al complaint investigation.				
	Date of Survey: 04/06/2015					
	Facility Number: 005043					
	Complaint # IN001629 Substantiated, State of allegations are cited.	983 deficiencies related to the				
	QA: cjl 04/28/15					
S 610	410 IAC 15-1.5-2 INF	ECTION CONTROL	S 610		5/26/15	
	410 IAC 15-1.5-2(f)(3)(D)(x)				
	(f) The hospital shall edinfection control command guide the infection program in the facility (3) The infection control responsibilities shall in not be limited to, the f (D) Reviewing and red in procedures, policies which are pertinent to control. These includimited to, the following	nittee to monitor n control as follows: rol committee nclude, but following: commending changes s, and programs infection e, but are not				
	(x) A program of food and storage for all per in food handling which is not limited to, the fo	rsonnel involved n includes, but				
	(AA) Storage of employation refrigerators.	oyee food in				
	(BB) Medications in n	utrition				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

PRINTED: 05/26/2015 FORM APPROVED

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		COMPLI	ETED			
		005043	B. WING		04/0	6/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE			
		700 BROA	DWAY				
ST JOSEF	PH HOSPITAL	FORT WA	YNE, IN 46802				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE	
S 610	Continued From page 1		S 610				
	refrigerators.						
	(CC) Refrigerator and temperature monitoring						
	and observation, the food that was used fo	t as evidenced by: tion review, staff interview, hospital failed to ensure the or a catering event was safe patients or customers.					
	Findings included:						
	reviewed 3/24/2013) shall be under sneeze employees shall conticontainers to ensure clean and sanitized swith the handles out cemployees shall contito ensure customers their bare hands; cou	that utensils are stored on a urface or in the containers of the food. The foodservice inually monitor the food bar are not: touching food with ghing, spitting, or sneezing oreign objects in the food;					
	(Executive Chef) indice the 6th, Cous Cous so a catering event for A member confirmed catering event for A monitored by foodser sneeze guards used to possibility of contaminal displayed on banquet	6/2015, staff member #4 cated early in the morning of alad was thrown together for dministration. The staff atering location was not vice staff nor was there any for the event to prevent the nation. The items were tables and were not d. After the catering event,					

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		005043	B. WING		04/06/2015
NAME OF P	ROVIDER OR SUPPLIER	1	ADDRESS, CITY, STATE	. ZIP CODE	1 0 0 5 2 0 . 0
			OADWAY	,	
ST JUSEF	PH HOSPITAL	FORT V	VAYNE, IN 46802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
S 610	Cous Cous will be us member #4 indicated taken throughout the there was no temperabe served again. 3. At 11:55 AM, a way A covered upright call white oblong ceramic salad in both contains observed with plastic with date marking of bowls was observed event.	t back to the kitchen, ed with three days. The sed for another meal. Staff I temperatures were not catering event to ensure ature abuse before it would alk-in cooler was inspected. It was observed with two bowls with Cous Cous ers. The bowls were wrap covering the salad "4/6 - 4/9". One of the two half empty from the catering	S 610		
S1118	and observation, the the hospital environm	he physical hospital developed and manner that the g of patients are Il be created or ay result in a ublic, or	S1118		5/26/15

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STATE FORM 6899 GM1811 If continuation sheet 3 of 4

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
74101 1244	or contraction	IDENTIFICATION NO.	A. BUILDING:		OOIVII EETEB	
		005043	B. WING		04/06/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST JOSEF	PH HOSPITAL	700 BROA				
	OLIMAN DV OT		NE, IN 46802	DDOWDEDIO DI AN OF CODDECTIO		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE COMPLE	
S1118	Continued From page 3		S1118			
	instances: cafeteria drink station; kitchen deep fryer station.					
	Findings included:					
	Services policy (last r	on and Control Nutritional evised 9/1/14) indicated the ean as often as needed to conditions.				
	heavily caked with so panels. It was also he surfaces of the double surface behind the tw with caked on blackis excessive grime and	leep fryers were observed il residue on the control eavily soiled on the exterior e deep fryers. The floor o deep fryers was observed h soil residue. The filth on and around the deep ute to the possibility of cross				
	The drink station cour feet in front of the wal counter was the tubin equipment located on The floor between the was observed heavily trash, loose cups, and					
	(Executive Chef) indic behind the drink static long time. The staff n does not have any do	6/2015, staff member #4 cated the floor surface on has not been cleaned in a nember indicated he/she ocumented evidence of when behind the drink station was				

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